State of Georgia
Division of Medical Assistance
Georgia Medicaid ESRD Enrollment Application

PART I – PATIENT INFORMATION

Name:		**Date of Birth:**	**Social Security No:**
Address:		**Medicaid ID No.:**	**Medicare Eligible**
Street or RFD		**Medicare Application Submitted**	
City **State** **Zip Code**		**[ ] Yes [ ] No**	
County:	**Medicare No.:**	**Effective Date:**	**Medicare Denied:** **[ ] Yes [ ] No**

Reason for Denial _____

_____

DOCUMENTATION SHOWING MEDICARE DENIAL MUST BE ATTACHED TO THIS FORM

PART II - TREATMENT INFORMATION - DIALYSIS

Date of First Treatment:	**Transplant Candidate:** **[ ] Yes [ ] No**	**Place of Dialysis:** **Home [ ] Clinic [ ]**
Name of Facility Transferred from:		
Mode of Treatment: **[ ] HEMODIALYSIS [ ] PERITONEAL DIALYSIS SELF DIALYSIS [ ]**		

PART III - TO BE COMPLETED BY PATIENT

I have elected to receive dialysis services provided by the facility shown on this application.

_____

Patient Signature **Date**

PART IV - PROVIDER INFORMATION	**DMA USE ONLY**	
Clinic Name:	**ESRD Enrolled:**	
Provider Number:	**Code:**	
Physician's Name: **Physician's Provider Number:**	**Effective Date:**	**Ending Date:**
Form Completed By:	**Approved By:**	
Name	**Date Approved:**	
Telephone No.	**Comments:**	
Title **Date**		

Mail to: Georgia Health Partnership (GHP)
P.O. Box 3000
McRae, Georgia 31055

DMA-615-89

Completion of the Georgia Medicaid ESRD Enrollment Application

(DMA-615-89)

This section provides specific instructions for completing the Georgia Medicaid ESRD Enrollment Application (DMA-615-89). A sample form is included for your reference.

Item 1 Member's Name
Enter the name exactly as listed on the Medicaid Eligibility Card (last name first).

Item 2 Member's Date of Birth
Enter the date of birth as month, day and year (April 15, 1994 would be listed as 04/15/94).

Item 3 Member's Social Security Number
Enter the Member's Social Security number exactly as it appears on the Social Security Card.

Item 4 Member's Address
Enter the street number, street name, post office box, county, state and zip code.

Item 5 Member's Medicaid I.D. No.
Enter the Member I.D. Number exactly as it appears on the Medicaid Eligibility Card.

Item 6 Medicare Eligibility
Enter "yes" if member is Medicare eligible.

Item 7 Medicare Application Submitted
Enter the date that the Medicare application was mailed.

Item 8 Medicare Number
Enter the Member's Medicare Number exactly as it appears on the Social Security Card.

Item 9 Effective Date
Enter the effective date of the Member's Medicare coverage.

Item 10 Medicare Denied
Check appropriate block indicating "Yes or No".

Item 11 Reason for Denial
Enter the reason for the Medicare denial.

Item 12 Date of First Treatment
Enter the date that the member was first treated in the dialysis facility.

Item 13 Transplant Candidate
Check the appropriate box indicating "Yes or No".

Item 14 Place of Dialysis
Check the appropriate block indicating the place of dialysis.

Item 15 Name of Facility Transferred From
Enter the name of the facility the member was transferred from.

Item 16 Mode of Treatment
Enter the appropriate mode of treatment.

Item 17 Clinic Name
Enter the facility providing treatment.

Item 18 Provider Number
Enter the facility's Medicaid provider number.

Item 19 Physician's Name and Provider Number
Enter the treating physician's name and Medicaid provider number.

Item 20 Form Completed By
Enter the name of the person completing this form.

Item 21 Telephone Number
Enter the telephone number (including Area Code) of the person completing the form.

Item 22 Title
Enter the title of the person completing the form.

Item 23 Date
Enter the date the form is completed.

NOTES

- **Part III requires that the member sign the ESRD Enrollment Application. This form *must* be signed to be a valid application. "Signature On File" is *not* acceptable.**

- **You *must* attach to the Enrollment Form a copy of the Medicare Application Form (HCFA/CMS 2728) *or* show proof of Medicare denial for coverage *or* attach a copy of Medicare eligibility card with effective dates.**

- **You must have proof of Medicare denial to extend enrollment beyond 90 days.**

- **You must notify the DMA of clinic transfer or change of physician.**

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